

Facility Name & ID Number Farmington Country Manor# 0045187 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>10</u>	Skilled (SNF)	<u>92</u>	<u>11,194</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>82</u>	Intermediate (ICF)	<u>0</u>	<u>22,386</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,276</u>	<u>3,490</u>		<u>12,766</u>	8
9	SNF/PED					9
10	ICF	<u>11,957</u>	<u>7,403</u>		<u>19,360</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,233</u>	<u>10,893</u>		<u>32,126</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.67%

D. How many bed-hold days during this year were paid by Public Aid?

105 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/1/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/1/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 92 and days of care provided _____Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	161,487	15,031	11,376	187,894		187,894		187,894			1
2	Food Purchase		156,581		156,581		156,581		156,581			2
3	Housekeeping	87,271	11,526		98,797		98,797		98,797			3
4	Laundry	57,550	13,969		71,519		71,519		71,519			4
5	Heat and Other Utilities			96,633	96,633		96,633		96,633			5
6	Maintenance	39,895	8,891	18,068	66,854		66,854		66,854			6
7	Other (specify):*											7
8	TOTAL General Services	346,203	205,998	126,077	678,278		678,278		678,278			8
	B. Health Care and Programs											
9	Medical Director			12,200	12,200		12,200		12,200			9
10	Nursing and Medical Records	1,056,830	45,635	33,011	1,135,476		1,135,476		1,135,476			10
10a	Therapy	53,418	10,320		63,738		63,738		63,738			10a
11	Activities	39,086	2,021	1,964	43,071		43,071		43,071			11
12	Social Services	31,588			31,588		31,588		31,588			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,180,922	57,976	47,175	1,286,073		1,286,073		1,286,073			16
	C. General Administration											
17	Administrative	57,171		126,000	183,171		183,171		183,171			17
18	Directors Fees											18
19	Professional Services			25,446	25,446		25,446		25,446			19
20	Dues, Fees, Subscriptions & Promotions			6,961	6,961		6,961	(4,054)	2,907			20
21	Clerical & General Office Expenses	49,768	10,129	87,105	147,002		147,002	(12,000)	135,002			21
22	Employee Benefits & Payroll Taxes			369,793	369,793		369,793		369,793			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,458	9,458		9,458		9,458			24
25	Other Admin. Staff Transportation			2,130	2,130		2,130		2,130			25
26	Insurance-Prop.Liab.Malpractice			78,403	78,403		78,403		78,403			26
27	Other (specify):*											27
28	TOTAL General Administration	106,939	10,129	705,296	822,364		822,364	(16,054)	806,310			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,634,064	274,103	878,548	2,786,715		2,786,715	(16,054)	2,770,661			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **Farmington Country Manor**

#0045187

Report Period Beginning: 1/1/01

Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			84,087	84,087		84,087	5,750	89,837			30
31	Amortization of Pre-Op. & Org.			13,407	13,407		13,407		13,407			31
32	Interest			268,463	268,463		268,463	(8,331)	260,132			32
33	Real Estate Taxes			42,000	42,000		42,000		42,000			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			407,957	407,957		407,957	(2,581)	405,376			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,088	34,240	35,328		35,328		35,328			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,466	50,466		50,466		50,466			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,088	84,706	85,794		85,794		85,794			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,634,064	275,191	1,371,211	3,280,466		3,280,466	(18,635)	3,261,831			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/01

Ending:

12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation			9
10	Interest and Other Investment Income	(7,703)	32	10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax			13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties	(628)	32	18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(12,000)	21	24
25	Fund Raising, Advertising and Promotional	(4,054)	20	25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule	5,750		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (18,635)	\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)		34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
37	(sum of SUBTOTALS (A) and (B))	\$ (18,635)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38	Medically Necessary Transport.		\$		38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)		\$		47

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$		1
2	Adjust depreciation expense to schedule XI	5,750	30	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	5,750		49

Summary A

12/31/01

	0	1
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[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,750	0	0	0	0	0	0	0	0	0	0	5,750	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,331)	0	0	0	0	0	0	0	0	0	0	(8,331)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,581)	0	0	0	0	0	0	0	0	0	0	(2,581)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(18,635)	0	0	0	0	0	0	0	0	0	0	(18,635)	45

Facility Name & ID Number Farmington Country Manor

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Report Period Beginning:

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Farmington Country Manor# 0045187

Report Period Beginning:

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **Farmington Country Manor** # **0045187** Report Period Beginning: **1/1/01** Ending: **12/31/01**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Health Care Cap. Finance		x	mortgage			\$ 2,200,000	\$ 2,056,823	6/1/04	11.3300	\$ 257,671	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Other interest										10,792	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,200,000	\$ 2,056,823			\$ 268,463	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,200,000	\$ 2,056,823			\$ 268,463	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Farmington Country Manor**# **0045187**Report Period Beginning: **1/1/01**Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																				
1. Real Estate Tax accrual used on 2000 report.		\$ 49,241	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 49,241	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$	3																																	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 42,000	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 42,000	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1996</td><td>43,603</td><td>8</td></tr> <tr><td>1997</td><td>47,364</td><td>9</td></tr> <tr><td>1998</td><td>48,457</td><td>10</td></tr> <tr><td>1999</td><td>40,524</td><td>11</td></tr> <tr><td>2000</td><td>49,241</td><td>12</td></tr> </table>	1996	43,603	8	1997	47,364	9	1998	48,457	10	1999	40,524	11	2000	49,241	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2000</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
1996	43,603	8																																		
1997	47,364	9																																		
1998	48,457	10																																		
1999	40,524	11																																		
2000	49,241	12																																		
FOR OHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Farmington Country Manor COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0045187

CONTACT PERSON REGARDING THIS REPORT Bob Conner

TELEPHONE 610-832-2059 FAX #: 610-834-2937

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> </u>	<u>Building</u>	\$ <u>49,241.00</u>	\$ <u>49,241.00</u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u>49,241.00</u>	\$ <u>49,241.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

A. Square Feet:

31,130

B. General Construction Type:

Exterior

Brick

Frame

Block

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home			\$ 34,115	1
2					2
3	TOTALS			\$ 34,115	3

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Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	92	1986		\$ 2,264,583	\$ 75,486	30	\$ 75,486	\$	\$ 1,171,123
5									
6									
7									
8									
Improvement Type**									
9	1987 Additions	1987		2,769	110	25	110		1,618
10	1988 Additions	1988		51,628	1,674	25	1,674		24,506
11	1989 Additions	1989		36,365	1,745	20	1,745		23,364
12	1990 Additions	1990		11,397	557	15	557		9,452
13	1991 Additions	1991		41,089	2,740	15	2,740		31,504
14	1992 Additions	1992		4,778	318	15	318		3,025
15	1993 Additions	1993		4,673	191	15	191		3,430
16	1994 Additions	1994		16,921	1,129	15	1,129		8,465
17	1995 Additions	1995		1,742	116	15	116		755
18	Carpet	2001		300		3	100	100	100
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,436,245	\$ 84,066		\$ 84,166	\$ 100	\$ 1,277,342	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 645	\$ 21	\$ 21	\$ 5,650	15	\$ 627	71
72	Current Year Purchases	38,625		5,650	5,650	7	5,650	72
73	Fully Depreciated Assets	261,766					261,766	73
74								74
75	TOTALS	\$ 301,036	\$ 21	\$ 5,671	\$ 5,650		\$ 268,043	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,771,396	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 84,087	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,837	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,750	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,545,385	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	2001 Ford Van	\$ 655.48	\$ 1,311	17
18		(extra payment)	195.00	195	18
19					19
20					20
21	TOTAL		\$ 850.48	\$ 1,506	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2002 \$ _____

13. _____/2003 \$ _____

14. _____/2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	Ln.10a, col 1&2	133	hrs	\$ 2,664		\$	\$ 226	133	\$ 2,890	1
2	Licensed Speech and Language Development Therapist	Ln.10a, col 1&2	329	hrs	11,457				329	11,457	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	Ln.10a, col 1&2	126	hrs	2,524			2,489	126	5,013	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				\$ 16,645		\$	\$ 2,715	588	\$ 19,360	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 130,171	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 11,299)	449,332		3
4	Supply Inventory (priced at)	3,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,501		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	489,042		8
9	Other(specify): Escrow Balance	158,918		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,238,964	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,115		13
14	Buildings, at Historical Cost	2,264,583		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	462,985		16
17	Accumulated Depreciation (book methods)	(1,539,635)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	35,747		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	26,090		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,283,885	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,522,849	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 69,844	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	29,744		29
30	Accrued Salaries Payable	130,511		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	2,852		36
37	Other Current Liabilities	278,033		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 552,984	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,027,080		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,027,080	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,580,064	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (57,215)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,522,849	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (83,255)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (83,255)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	26,040	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 26,040	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (57,215)	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning: 1/1/01

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,111,794	1
2	Discounts and Allowances for all Levels	(1,047,046)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,064,748	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	86,164	6
7	Oxygen	26,150	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 112,314	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	30,361	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	54,728	21
22	Laundry	36,652	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 121,741	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,703	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,703	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,306,506	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	678,278	31
32	Health Care	1,286,073	32
33	General Administration	822,364	33
B. Capital Expense			
34	Ownership	407,957	34
C. Ancillary Expense			
35	Special Cost Centers	35,328	35
36	Provider Participation Fee	50,466	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,280,466	40
41	Income before Income Taxes (line 30 minus line 40)**	26,040	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 26,040	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning: 1/1/01

Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		2,128	\$ 50,679	\$ 23.82	1
2	Assistant Director of Nursing		1,691	34,224	20.24	2
3	Registered Nurses		1,861	52,565	28.25	3
4	Licensed Practical Nurses		22,047	329,580	14.95	4
5	Nurse Aides & Orderlies		56,297	511,272	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist		588	16,645	28.31	7
8	Rehab/Therapy Aides		4,824	71,642	14.85	8
9	Activity Director		2,168	24,725	11.40	9
10	Activity Assistants		1,984	14,361	7.24	10
11	Social Service Workers		2,088	31,588	15.13	11
12	Dietician					12
13	Food Service Supervisor		1,969	22,811	11.59	13
14	Head Cook		4,034	29,265	7.25	14
15	Cook Helpers/Assistants		13,911	109,411	7.87	15
16	Dishwashers					16
17	Maintenance Workers		3,395	39,895	11.75	17
18	Housekeepers		11,483	87,271	7.60	18
19	Laundry		7,828	57,550	7.35	19
20	Administrator		2,168	57,171	26.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager		2,046	29,090	14.22	23
24	Clerical		2,046	20,678	10.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator		2,128	43,641	20.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		146,684	\$ 1,634,064 *	\$ 11.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	72	\$ 11,201	Ln 1, Col 3	35
36	Medical Director	36	12,200	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	800	Ln 11, Col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dentist	24	1,897	Ln 10, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	240	\$ 27,898		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **Farmington Country Manor**

XIX. SUPPORT SCHEDULES

STATE OF ILLINOIS

0045187

Report Period Beginning: **1/1/01**

Page 21

Ending: **12/31/01**

<p>A. Administrative Salaries</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Keith Fisher</td> <td>Administrator</td> <td style="text-align: center;">0</td> <td style="text-align: right;">\$ 30,340</td> </tr> <tr> <td>Melissa Pate</td> <td>Administrator</td> <td style="text-align: center;">0</td> <td style="text-align: right;">26,831</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 57,171</td> </tr> </tbody> </table> <p>B. 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* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number <u>Farmington Country Manor</u>	STATE OF ILLINOIS # <u>0045187</u>	Report Period Beginning: <u>1/1/01</u>	Ending: <u>12/31/01</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
 If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,500 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? YES X NO _____

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
Genesis Health Ventures operated facility until 10/31/00

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 50,466
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ _____

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? 100
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? _____
 Firm Name: No The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
 Attach invoices and a summary of services for all architect and appraisal fees.